

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13652 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13658

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certifying physician, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Dorchester	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	b. COUNTY Dorchester				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	c. LENGTH OF STAY IN lb 6 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 501 Maryland Ave.,	d. STREET ADDRESS 501 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ralph Rodgers Adkins	First	Middle	Last	4. DATE OF DEATH Dec. 14, 1959	Month	Day	Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH March 9, 1906	9. AGE (in years last birthday) 53 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt. Maintenance at Hospital, retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Bloomington, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Benjamin E. Adkins		14. MOTHER'S MAIDEN NAME Mary Ann Webb					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War I 307-14-2125		17. INFORMANT Mrs. Margaret D. Adkins, 501 Maryland Ave., Camb., Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH Instant							
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)							
DUE TO (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>		DATE SIGNED 12/15/59					
EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1959	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery	22d. LOCATION (City, town, or county) Cambridge, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth S. Shone</i>		ADDRESS Cambridge, Md.	24a. REC'D BY REGISTRAR DEC 21 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

07 SEPTEMBER 1967
STATE OF CALIFORNIA

44-1967-1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13675

CERTIFICATE OF DEATH

13639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. R.F.D. # 3 Life		c. LENGTH OF STAY IN 16 None				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md. R.F.D. # 3.				
3. NAME OF DECEASED (Type or print) Margie		First	Middle			
		Last	Barnes			
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/22/1879			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Daniel Lambgin		14. MOTHER'S MAIDEN NAME Elizabeth				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No Unknown	17. INFORMANT Le Compte Funeral Service, Records.			
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>						
DUE TO <u>renal disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Arteriosclerotic hypertensive cardion vascular</u>						
DUE TO <u>Arteriosclerosis, generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 year +</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	20f. (City or town) ---	(County)	(State)
21. I certify that I attended the deceased from <u>9-17</u> , 19 <u>59</u> , to <u>12-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-17-59</u> , 19 <u>59</u> , and that death occurred at <u>7:30A.M.</u> from the causes and on the date stated above.						
ADDRESS (Street, city or town, state) <u>M.D. 15 Locust Street, Cambridge, Md.</u> DATE SIGNED <u>12-18-59</u>						
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/19/59	22c. NAME OF CEMETERY OR CREMATORIAL Brick Church	22d. LOCATION (City, town, or county) Taylors Island, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 29 '59 DATE	24b. REGISTRAR'S SIGNATURE Oliver S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. 2010년 1월 1일부터 2010년 12월 31일까지 10년간 적용되는 세율은 10%입니다.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13660

CERTIFICATE OF DEATH

Reg. Dist. No.

13640

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 43 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Beasley		First	Middle	Last	4. DATE OF DEATH December 4, 1959	Month	Day	Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 4, 1959	9. AGE (In years lost birthday) yrs. 19	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 19	Hours 27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Roy Lee Cornish		14. MOTHER'S MAIDEN NAME Sarah Bell Beasley						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no		none		Sarah Bell Beasley - Cambridge Md. Route # 2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity INTERVAL BETWEEN ONSET AND DEATH 4.3 hrs 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (Maternal Cause Unknown) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 12-4 , 19 59 , to 12-5 , 19 59 , that I last saw the deceased alive on 12-5 , 19 59 , and that death occurred at 9:45 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Eldridge H. Wolff M.D. ADDRESS (Street, city or town, state) Cambridge, Maryland DATE SIGNED 12-6-59								
PHYSICIAN'S NAME (Type) Dr. Eldridge H. Wolff		15 Locust Street - Cambridge, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/59		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery		22d. LOCATION (City, town, or county) Cambridge, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ray Lee Cornish - Harbo, MD		ADDRESS 2067161XVI		24a. REC'D BY REGISTRAR DATE DEC 9 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		

CERTIFICATE OF DEATH

John H. Johnson

January 20, 1970

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13661

CERTIFICATE OF DEATH

Reg. Dist. No.

13641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		d. STREET ADDRESS 108 N. Higgins			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glasgow Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAY N. BRINSFIELD		First	Middle	Lost	4. DATE OF DEATH Dec. 11,	Month	Day	Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1880		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME William B. Newnam		14. MOTHER'S MAIDEN NAME Edith Parsons							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. William Brinsfield		Address Cordova, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		INTERVAL BETWEEN ONSET AND DEATH 10 days					
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Priapic nevus lower lumbosacral region						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) olive							
20c. TIME OF INJURY Hour o. p.m. 19	Month Dec.	Day 14	Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Spring Hill Cemetery	20f. (City or town) Cambridge, Md.	(County) Easton, Maryland	(State) MD	
21. I certify that I attended the deceased from 11/9/59 , 19 59 , to 12/14 , 19 59 , that I last saw the deceased alive on 11/10/59 , 19 59 , and that death occurred at 1030A M, from the causes and on the date stated above. ACTUAL SIGNATURE A. Thompson									
ADDRESS (Street, city or town, state) 6 Locust St., Cambridge, Md. DATE SIGNED Dec 13 59									
PHYSICIAN'S NAME (Type) Dr. A. H. Thompson									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Dec. 14, 1959	22c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Cemetery		22d. LOCATION (City, town, or county) Easton, Maryland		(State) MD			
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.		24a. REC'D BY REGISTRAR DEC 16 '59		24b. REGISTRAR'S SIGNATURE John E. Thompson			

WISCONSIN STATE DEPARTMENT OF HIGHWAYS - AUTOMOBILE REGISTRATION

CERTIFICATE OF DATA

1968

REGISTRATION NO.	EXPIRATION DATE	OWNER'S NAME	VEHICLE DESCRIPTION
1968-1111	11/18/68	JOHN W. GUTHRIE	1968 CHEVROLET CORVETTE
I hereby declare that the information contained in this certificate is true and correct.			
John W. Guthrie Signature			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3, 5, 9 Film G253 12-17-59 et

13642

CERTIFICATE OF DEATH

Reg. Dist. No.

13662

1. PLACE OF DEATH
a. COUNTY

Dorchester

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

CAMBRIDGE

c. LENGTH OF STAY IN lb

14 DA.

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

CAMBRIDGE Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Talbot

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Oxford

20X-2

d. STREET ADDRESS

Box 191

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

(Gertrude)

Middle

Last

4. DATE
OF
DEATHMonth
12Day
1Year
1959

5. SEX

Female
Male

6. COLOR OR RACE

Col

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

4/12/85

9. AGE (In years
last birthday)

77 1/2 yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Cook

10b. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph H. Queen

14. MOTHER'S MARRIED NAME

Priscilla Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)

16. SOCIAL SECURITY NO.

217-36-8438

17. INFORMANT

Joseph Chase, Oxford

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Cardiac Decompensation

INTERVAL BETWEEN
ONSET AND DEATH

420.0

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)

Arteriosclerotic heart disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from November 1957 to December 1959, that I last saw the deceased alive on December 1, 1959, and that death occurred at M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state)ACTUAL
SIGNATURE*J. Edwin Fassett*

M.D. 227 Pine St-Camb., Md.

DATE SIGNED
12-3-59PHYSICIAN'S
NAME (Type)

J. Edwin Fassett, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

James B. Marshall

ADDRESS

24a. REC'D BY REGISTRAR

DAT

24b. REGISTRAR'S SIGNATURE

Arthur S. Knue

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13676

CERTIFICATE OF DEATH

Reg. Dist. No. 14359

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD #1		e. STREET ADDRESS RFD #1	
3. NAME OF DECEASED (Type or print) Bertha G. Cummings		4. DATE OF DEATH Dec 29 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 29, 1836
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alexander Plater		14. MOTHER'S MAIDEN NAME Luisa J. Keene Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Robert Cummings, RFD #1, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1959, to Dec 29 1959, that I last saw the deceased alive on December 29 1959, and that death occurred at 7 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 227 Pine St-Cambridge, Md. 1-2-60 DATE SIGNED			
ACTUAL SIGNATURE J. Edwin Fassett		PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.	
22a. BURIAL, CREMATION, REMOVAL (S) <input type="checkbox"/> Burial		22b. DATE THEREOF 1/3/1960	
22c. NAME OF CEMETERY OR CREMATORIUM Old Field Cemetery		22d. LOCATION (City, town, or county) (State) Dorchester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE: Hubert McLaughlin Jr.		24a. REC'D BY REGISTRAR DATE JAN 7 '60	
ADDRESS Cambridge, Md.		24b. REGISTRAR'S SIGNATURE O. Wm. & Hause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14360

13663

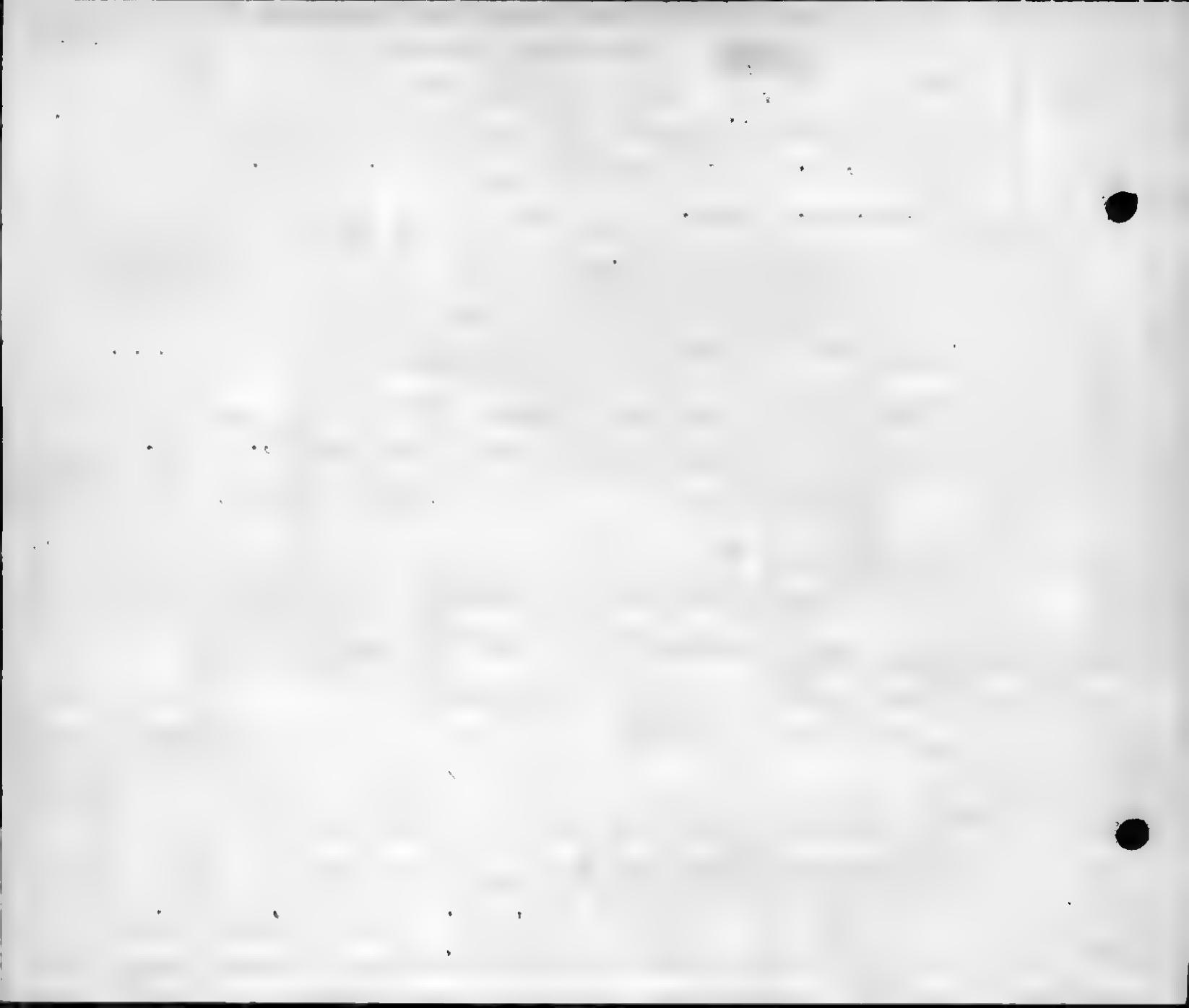
CERTIFICATE OF DEATH

Req. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co.			MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lakesville, Maryland.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Md. Hospital.			e. STREET ADDRESS None					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sangston	Middle G.	Last Dixon	4. DATE OF DEATH	Month 12	Day 24	Year 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/19/1902	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months 57	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Supervisor		10b. KIND OF BUSINESS OR INDUSTRY Sea Food Plant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Dixon				14. MOTHER'S MAIDEN NAME Annie Dixon					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Le Compte Funeral Service, Records,		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of urinary bladder DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause lost. with metastases								INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Sept - 5, 1958, to Dec 24, 1959							
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cambridge		(County) Cambridge	(State) Maryland	
21. I certify that I attended the deceased from Sept - 5, 1958, to Dec 24, 1959 , that I last saw the deceased alive on Dec 24, 1959 , and that death occurred at 1:50 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Lewis M. Burdette, M.D.								ADDRESS (Street, city or town, state) 1 Locust St., Cambridge, Md.	
PHYSICIAN'S NAME (Type) Lewis M. Burdette								DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/27/59	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park.			22d. LOCATION (City, town, or county) Cambridge, Maryland.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland		ADDRESS Le Compte Funeral Service, Cambridge, Maryland			24a. REC'D BY REGISTRAR JAN 8 '60		24b. REGISTRAR'S SIGNATURE Civilla S. Knarr		

HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

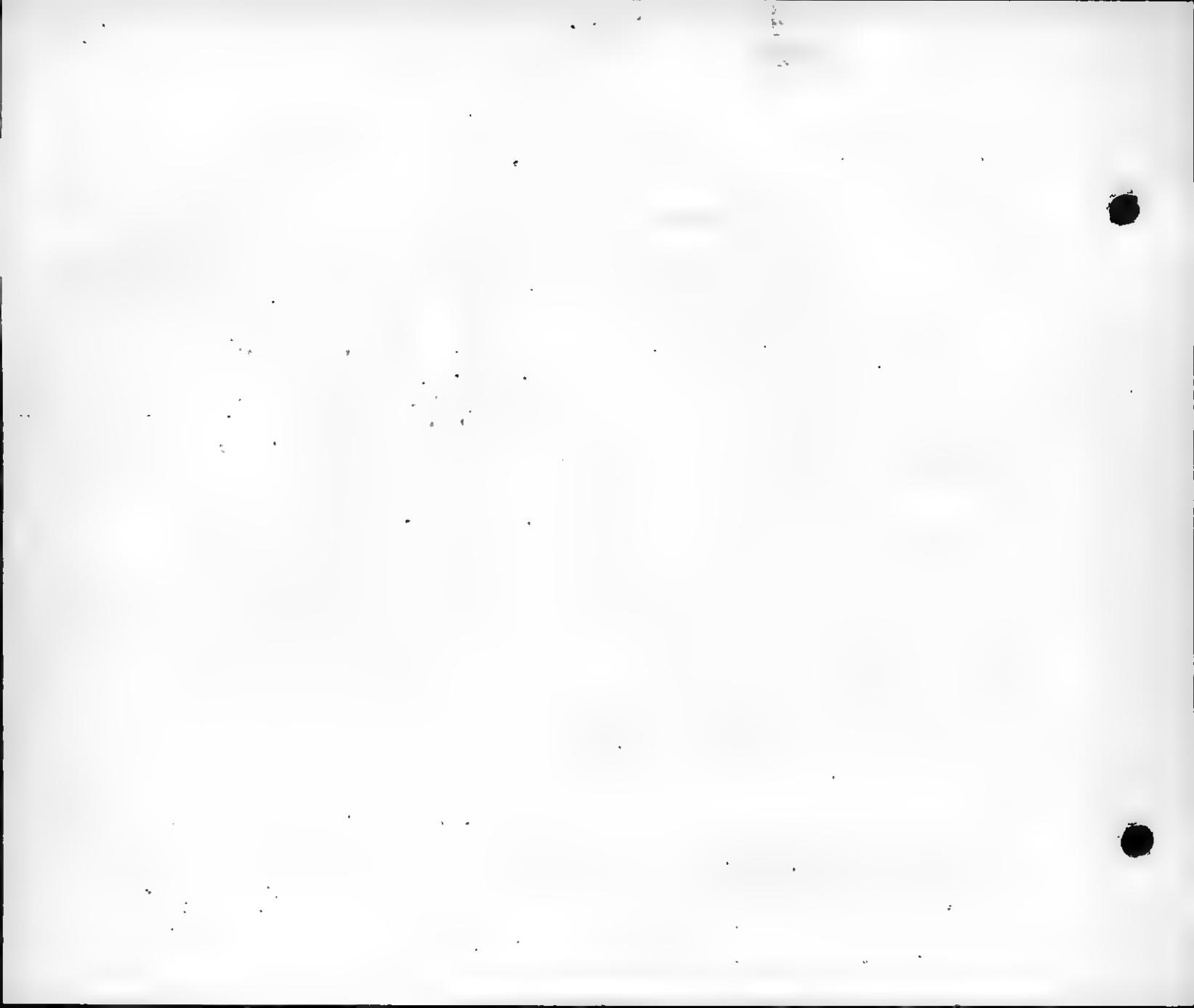
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL & **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page **1** may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 13643	
Item 1 Film G253 12-16-59 et 13677 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		a. STATE					
rural Cambridge				Maryland Wicomico		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS					
rural Cambridge		1 M 3 Days		Salisbury		295 Lincoln					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM?		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Eastern Shore State Hospital											
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
Mari Ellen Ennis					Dec	5	1959				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
F		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	June 28 1874	85 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
House Work at Home		None		Md. (Wico. County, Md.)		USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME									
Joseph Wedder		Marie Shockley									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT				17. WAS AUTOPSY PERFORMED?			
No				Mrs. Stella Solloway (Daughter) Snow (Hospital records)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Hill, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cancer of Tongue</u>										unk	
141.9 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b).											
DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
19											
21. I certify that I attended the deceased from <u>Nov 2</u> , 1959, to <u>Dec 5</u> , 1959, that I last saw the deceased alive on <u>Dec 5</u> , 1959, and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.											
ADDRESS (Street, city or town, state)										DATE SIGNED	
<u>Thomas J. Dredge</u> M.D. E.S.S. Hospital, Cambridge, Md. 12-5-59											
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)									
		Thomas J. Dredge									
22a. BURIAL CREMATION, 22b. DATE THEREOF REMOVAL (Specify)		22c. NAME OF CEMETERY OR Crematory		22d. LOCATION (City, town, or county)		(State)					
Burial Dec 3-1959 Wicomico Mem. Park Salisbury Md.											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<u>Hillong & Son, Salisbury, Md.</u>				DEC 8 '59		<u>Arthur S. Kraus</u>					
VS A15 (4) 15M 9/58											



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13664

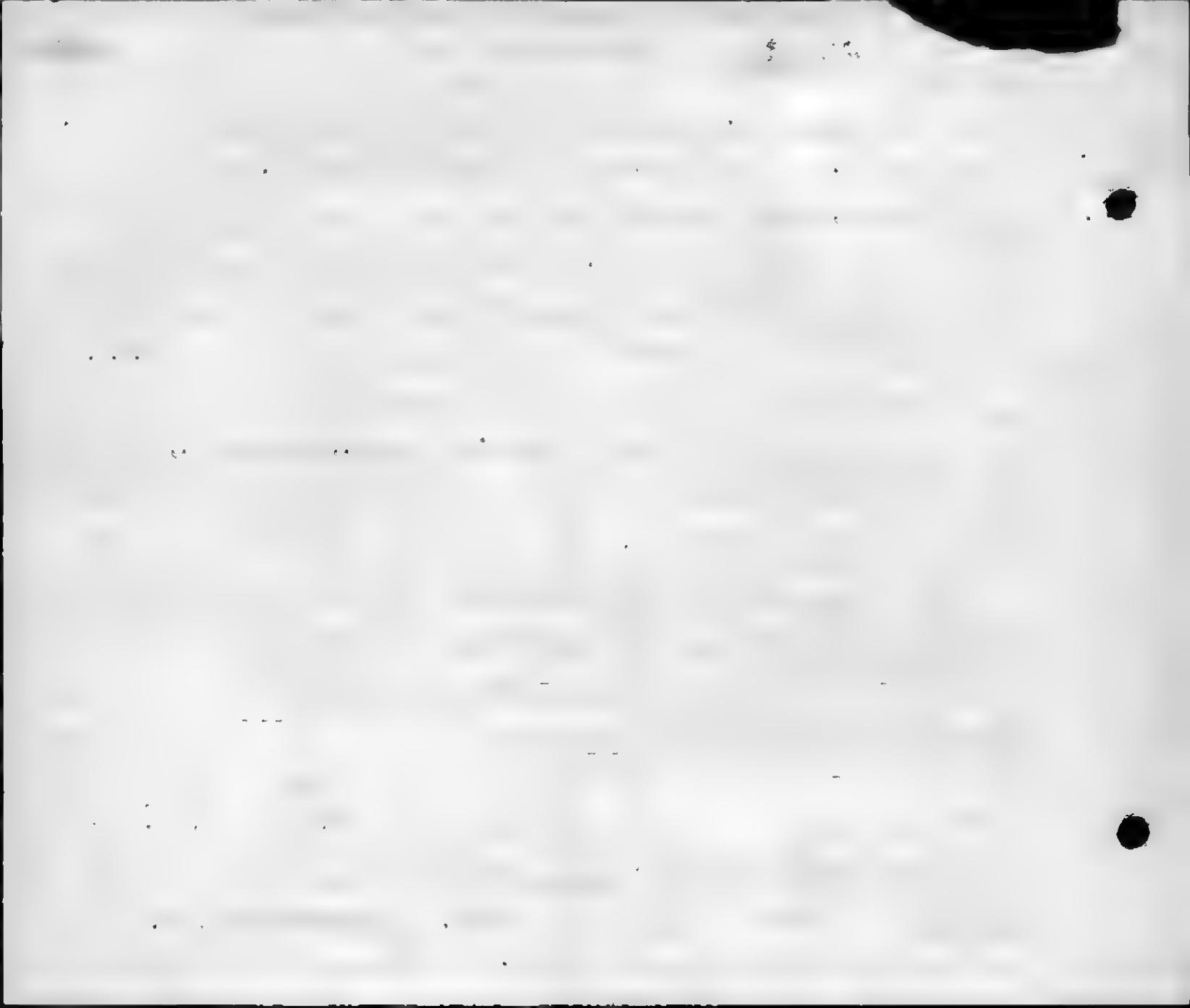
CERTIFICATE OF DEATH

Reg. Dist. No.

14380

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.	c. LENGTH OF STAY IN 1b 1 week	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X East New Market, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Maryland Hospital	d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Eva S. Middle Harvey	Last	4. DATE OF DEATH 1 2 / 27 /	Month 19 Year 59
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8 / 7 / 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Storr		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs Leonard Cannon, Choptank Ave., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hemiplegia, right		4 days	
DUE TO (c) Arteriosclerosis, generalized		unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. -- 19 p. m. --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 12-2-59, 19, to 12-27-59, 19, that I last saw the deceased alive on 12-27-59, 19, and that death occurred at 11:15PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. 12-28-59			
PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/59	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS East New Market Cemetery		22d. LOCATION (City, town, or county) East New Market, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR DATE JAN 11 '60	
		24b. REGISTRAR'S SIGNATURE Cuthbert S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13665

CERTIFICATE OF DEATH

Reg. Dist. No.

13645

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Few hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylors Island				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert		First J.	Middle Henson	4. DATE OF DEATH Dec. 3, 1959	Month Dec.	Day 3	Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1886	9. AGE (In years lost birthday) 73 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert J. Henson				14. MOTHER'S MAIDEN NAME Sophia Keene				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 17. INFORMANT Josephine Henson, Taylors Island, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Cerebral Hemorrhage				INTERVAL BETWEEN ONSET AND DEATH 30 HOURS				
(b) DUE TO HYPERTENSION				10 YEARS				
(c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6/9/1959	20f. (City or town) 12/3/1959	(County) (State)	
21. I certify that I attended the deceased from 6/9/1959 to 12/3/1959 , that I last saw the deceased alive on 12/2/1959 , and that death occurred at 3 AM M.D., from the causes and on the date stated above.								
ACTUAL SIGNATURE W.E. Gunby Jr.				ADDRESS (Street, city or town, state) 105 Church St. Cambridge, MD.				
PHYSICIAN'S NAME (Type) W.E. Gunby Jr.				DATE SIGNED 4 Dec 59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/1959	22c. NAME OF CEMETERY OR CREMATORIUM Smithville Cemetery	22d. LOCATION (City, town, or county) Dorchester Co., Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Herbert McElveen Jr.				24a. REC'D BY REGISTRAR DEC 8 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13646

13678

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 16 18 MONTHS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) ROBERT EMMETT JACKSON		4. DATE OF DEATH DEC. 5, 1959	Month Day Year				
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-78				
9. AGE (In years last birthday) 81 yrs	10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY FARM					
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MARTIN T. JACKSON		14. MOTHER'S MAIDEN NAME PERCELY					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN		16. SOCIAL SECURITY NO 213-12-5707					
17. INFORMANT HOSPITAL RECORDS		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYPER TENSIVE CARDIOVASCULAR DISEASE 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERAL ARTERIOSCLEROSIS DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 17, 1958 , to DEC. 4, 1959 , that I last saw the deceased alive on DEC. 4, 1959 , and that death occurred at 8:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Ettore DeFilippis</i>		ADDRESS (Street, city or town, state) <i>M.D. Eastern Shore State Hospital</i>		DATE SIGNED <i>1959</i>			
PHYSICIAN'S NAME (Type) ETTORE DEFILIPPIS				CAMBRIDGE, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery		22d. LOCATION (City, town, or county) St. Michaels, Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hamilton Harrison</i>		ADDRESS <i>St. Michaels, Md</i>		24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN! The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

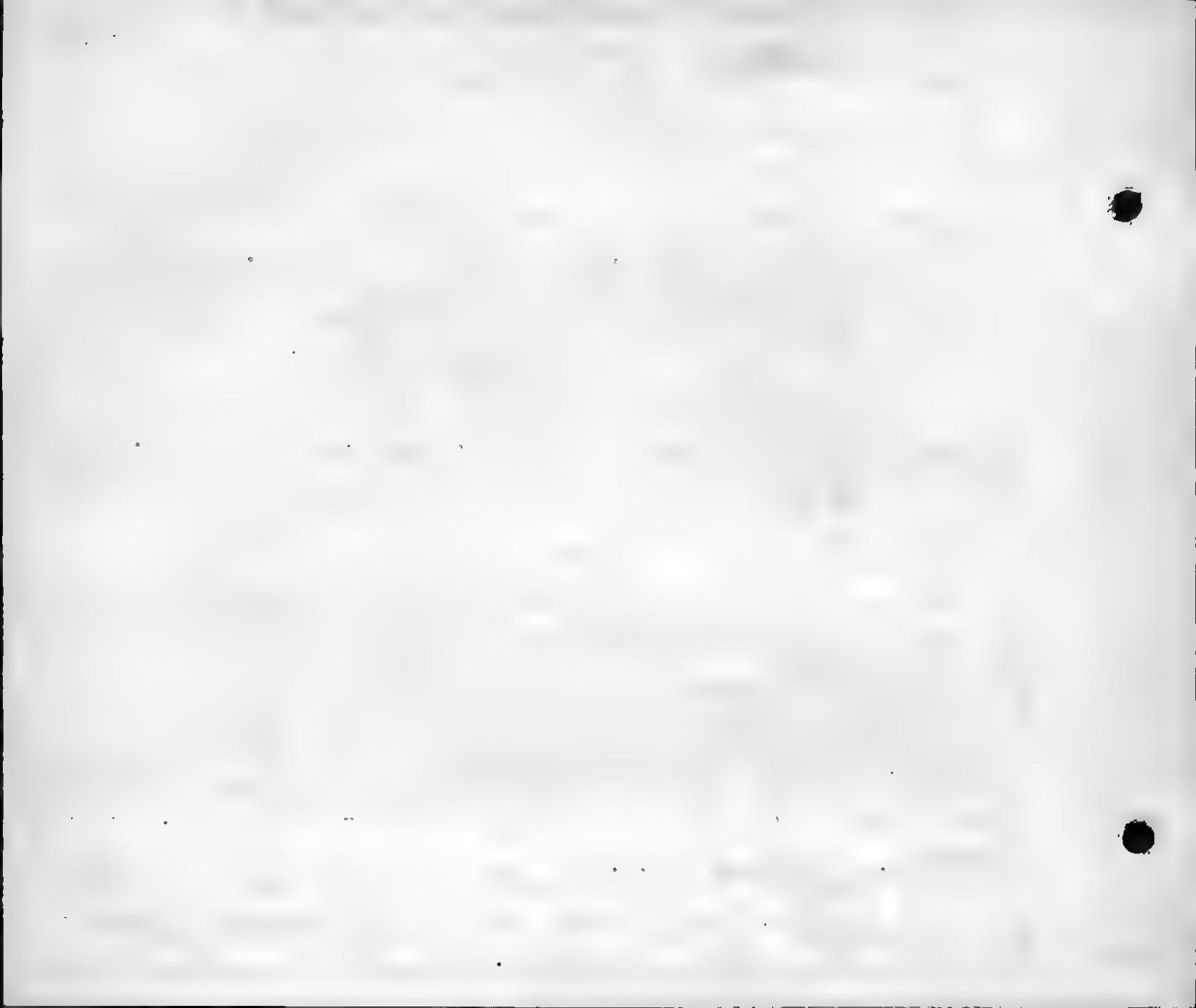
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CERTIFICATE OF DEATH

14361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL Cambridge		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 427 High Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillie		First B.	Middle Jolley
Last Jolley		4. DATE OF DEATH Dec. 21, 1959	Month Day Year
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 26, 1878
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Caroline County, Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Adams		14. MOTHER'S MAIDEN NAME Henrietta Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Edyth M. Jolley, Cambridge, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
X DUE TO Cerebral Hemorrhage			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 15 1959 , to Dec. 21, 1959 , that I last saw the deceased alive on December 21, 1959 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 12-26-59			
ACTUAL SIGNATURE <i>J. Edwin Fassett</i>		PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/27/1959	22c. NAME OF CEMETERY OR CREMATORIUM Salem Cemetery	22d. LOCATION (City, town, or county) Dorchester County, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Hanna</i>		24a. REC'D BY REGISTRAR DATE JAN 7 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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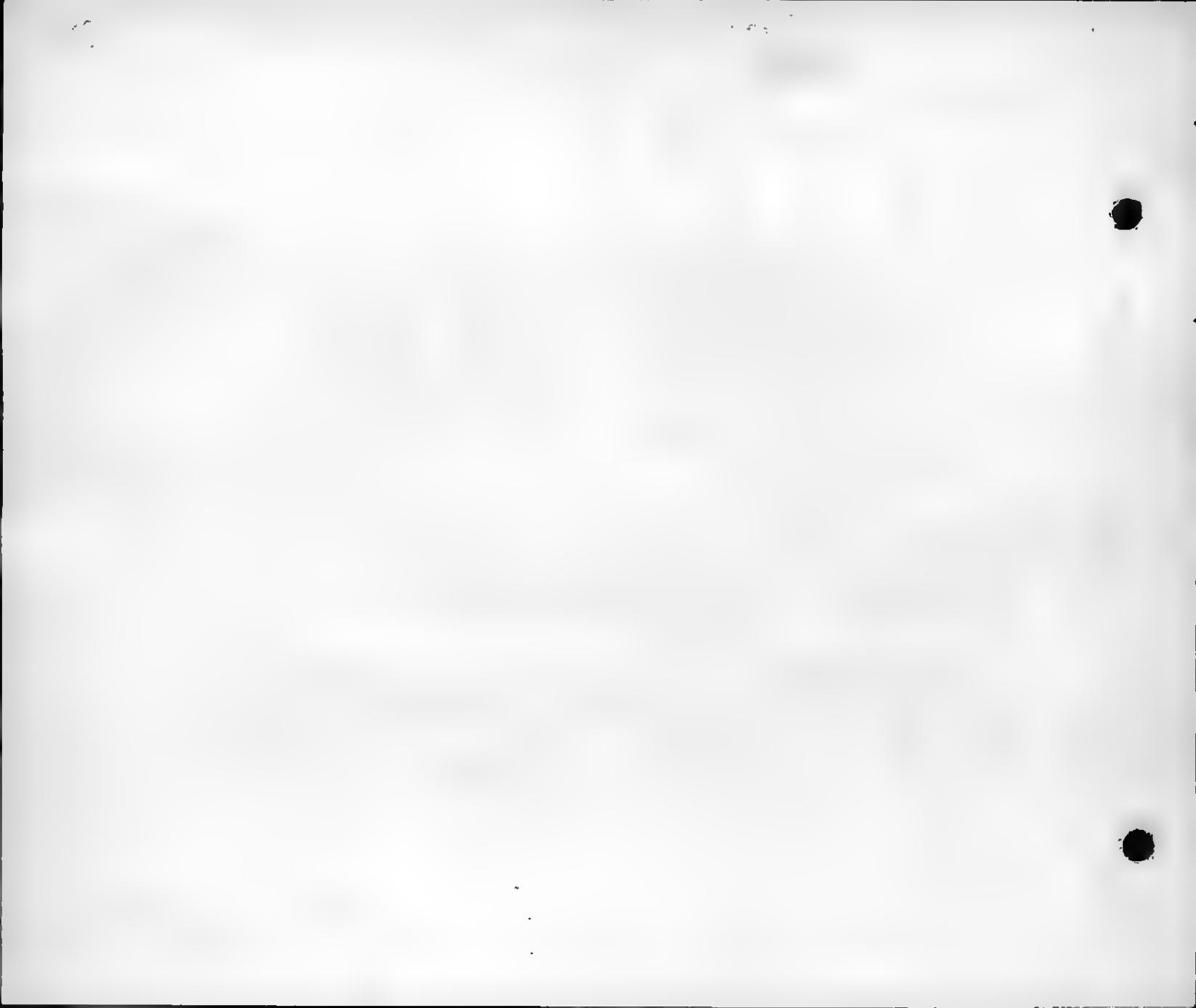
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the Hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Elwood		d. STREET ADDRESS Near Elwood		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie		First	Middle Gertrude	Last Jones	4. DATE OF DEATH December 31, 1959,	Month December	Day 31	Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1870		9. AGE (in years last birthday) yrs. 89	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Lou Cephas					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Spencer C. Jones, Hurlock, Maryland, R.F.D.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Hemiplegia DUE TO Generalized Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 6 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						25 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Jan. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/15 , 19 59 , to 12/31 , 19 59 , that I last saw the deceased alive on 12/15 , 19 59 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Frederick B. Freeman		M.D.		ADDRESS (Street, city or town, state) Preston Morgan		DATE SIGNED 1/2/60			
PHYSICIAN'S NAME (Type) Harold J. Frimpong									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 3, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Washington Cemetery		22d. LOCATION (City, town, or county) Near Hurlock, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frimpong and Son, Federalsburg, Maryland				ADDRESS J.J. Frimpong and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR JAN 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13647

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		d. STREET ADDRESS 3 Hubbard	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3 Hubbard				d. STREET ADDRESS 3 Hubbard		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sarah	Middle Elizabeth	Last JONES	4. DATE OF DEATH	Month 12	Day 2	Year 1959
5. SEX F	6. COLOR OR RACE col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MAR. 2	9. AGE (In years lost birthday) 72 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 72	Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Nathaniel Chase		14. MOTHER'S MAIDEN NAME Mary Ann Roberts		Address John Jones Combudge, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 181.0		Carcinoma of Urinary Bladder					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO					
{		DUE TO					
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 1958, to December 2959, that I last saw the deceased alive on December 2, 1959, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 227 Fine St-Camp, Md.						DATE SIGNED 12-3-59	
ACTUAL SIGNATURE J. Edwin Fassett							
PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/5/59		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cem.		22d. LOCATION (City, town, or county) Cambridge Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Marshall, Easton, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Keane	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-pass permit. Then please remove carbon papers. Pages 1 or 2 should be filed with the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13680

CERTIFICATE OF DEATH

13648

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville		c. LENGTH OF STAY IN lb entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toddville		d. STREET ADDRESS Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Flowers Jones		First	Middle	Last	4. DATE OF DEATH December 21, 1959	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1878	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS DAYS	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Food Canner		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Toddville		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Thomas Jones		14. MOTHER'S MAIDEN NAME Adeline E. Ross		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT W. Paul Jones, Cambridge, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month o. m. 19	Doy 19	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 1/15 , 19 58 , to 21 DEC , 19 59 that I last saw the deceased alive on 19 , and that death occurred at 4:00 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Walter E. Gundy Jr PHYSICIAN'S NAME (Type) WALTER E. GUNDY JR ADDRESS Cambridge DATE SIGNED 23 Dec. M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 24, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Jones Family Cemetery		22d. LOCATION (City, town, or county) Toddville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Shower		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thorne			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13669

CERTIFICATE OF DEATH

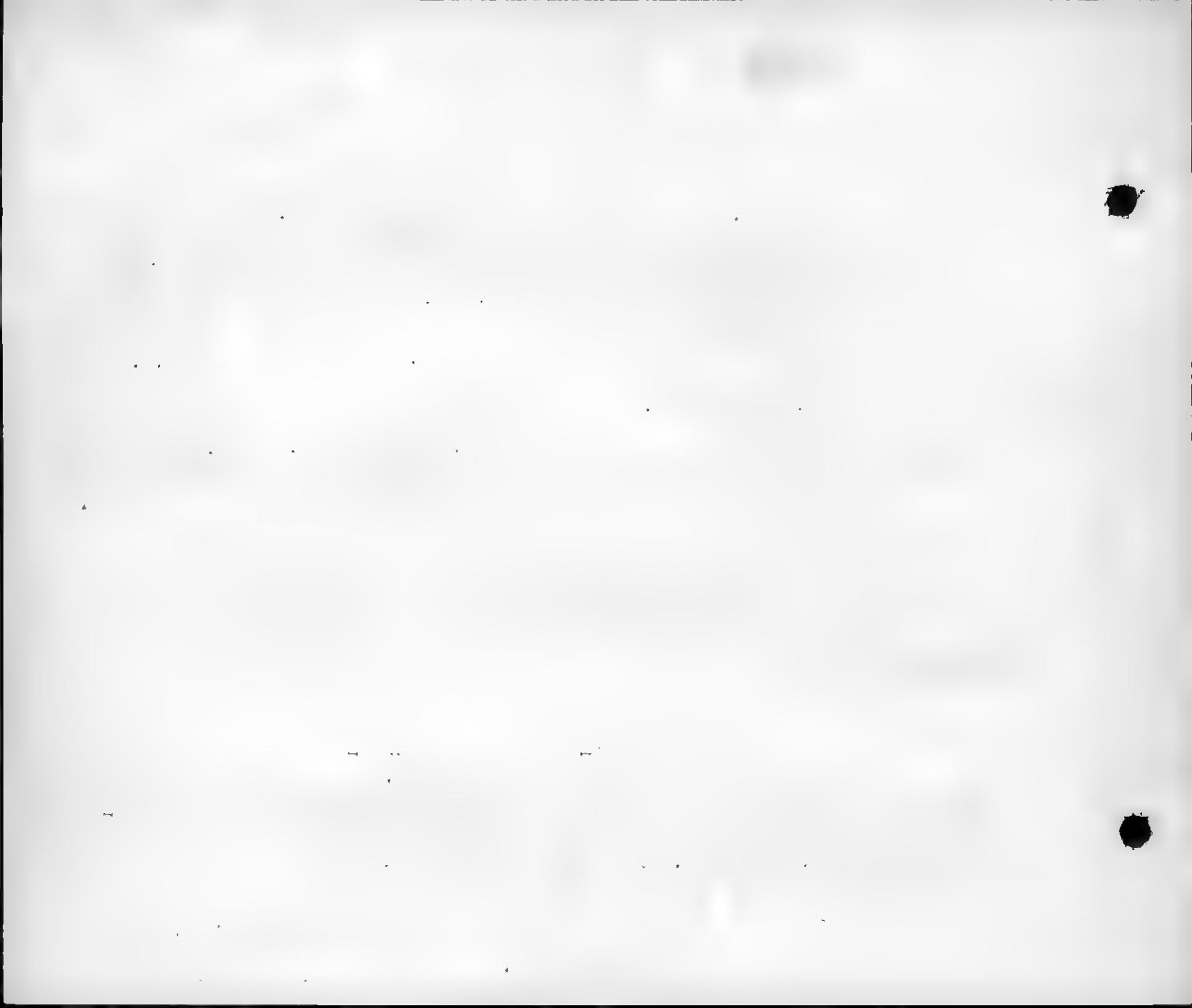
13649

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 30 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 215 Maryland Ave.,				d. STREET ADDRESS 215 Maryland Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Lost	4. DATE OF DEATH Leonard, Jr.	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1900	9. AGE (In years lost birthday) 59 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automobile Dealer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME William H. Leonard, Sr.		14. MOTHER'S MAIDEN NAME Mattie Dean						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Mary Blanche Leonard, 215 Md. Ave., Cambridge		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE						INTERVAL BETWEEN ONSET AND DEATH 8 hrs.		
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 20g. (County) 20h. (State)				
21. I certify that I attended the deceased from 11-26-44 , 19, to 12-15-59 , 19, that I last saw the deceased alive on 12-15-59 , 19, and that death occurred at 5:00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Albert E. Bunker</i> M.D.		ADDRESS (Street, city or town, state) 200 Maryland Avenue		DATE SIGNED 11-16-59				
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		Cambridge, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 17, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Stevens</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE DEC 21 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13670

CERTIFICATE OF DEATH

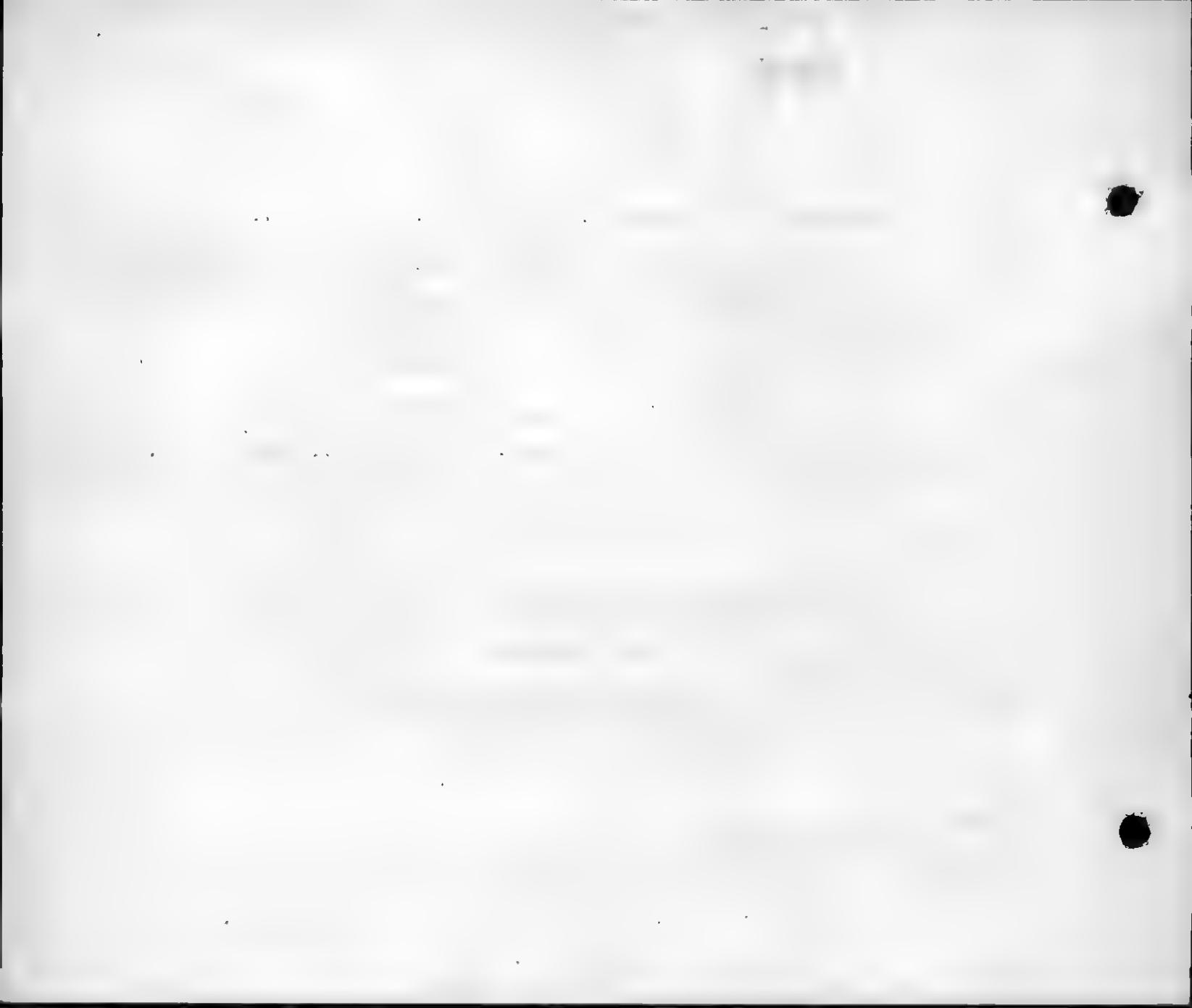
Reg. Dist. No.

13651

1. PLACE OF DEATH o COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN lb entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS 209 W. Appleby Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Leon Lewis, Jr.		First	Middle
4. DATE OF DEATH	Month Dec. 28, 1959	Day 19	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1959
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 3	
11. IF UNDER 24 HRS Days 0		Hours 0	
12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Robert Leon Lewis, Sr.		14. MOTHER'S MAIDEN NAME Elsie Diane Holliday	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. Address 209 W. Appleby Ave.,	
(If yes, give war or date of service)		17. INFORMANT Robert. Leon Lewis, Sr., Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.3 DUE TO <i>extreme arterial reflex</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Constricting Heart Failure</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-26, 1959 to 12-25, 1959, that I last saw the deceased alive on 4-28-1959, and that death occurred at 4:00 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE <i>J.W. Brown, M.D.</i>		ADDRESS (Street, city or town, state) <i>Cambridge, Md.</i> DATE SIGNED <i>12-29-59</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM Green Lawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geneth R. Stevens</i>		24a. REC'D BY REGISTRAR ADDRESS <i>Cambridge, Md.</i> DATE <i>JAN 5 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Carroll E. Kline</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13671

CERTIFICATE OF DEATH

14364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Parker	Middle 	Last Parker		
4. DATE OF DEATH	Month December	Day 31	Year 19 59		
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-59		
9. AGE (in years last birthday) yrs. 	10. IF UNDER 1 YEAR Months 7	11. IF UNDER 24 HRS. Days 45	12. IF UNDER 24 HRS. Hours 7		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Clarence Cephas	14. MOTHER'S MAIDEN NAME Lucille Mae Parker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 773.5	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT Lucille Mae Parker	Address Hurlock, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Premature (at 1b. 8g) DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 8 hours			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 227 Pine St.	20f. (City or town) Cambridge	(County) Maryland	(State) MD
21. I certify that I attended the deceased from 12-30-59 to 12-30-59 that I last saw the deceased alive on 12-30-59 , and that death occurred on 12-30-59 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. Edwin Fessett</i> ADDRESS (Street, city or town, state) 227 Pine St. DATE SIGNED 1-3-60					
PHYSICIAN'S NAME (Type) Dr. J. Edwin Fessett - 227 Pine Street, Cambridge, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1-2-60	22c. NAME OF CEMETERY OR CREMATORIUM Cambridge Maryland Hospital	22d. LOCATION (City, town, or county) Cambridge	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John L. Knue</i>	ADDRESS 2067185XV	24a. REC'D BY REGISTRAR DATE JAN 8 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knue</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the funeral director.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13681

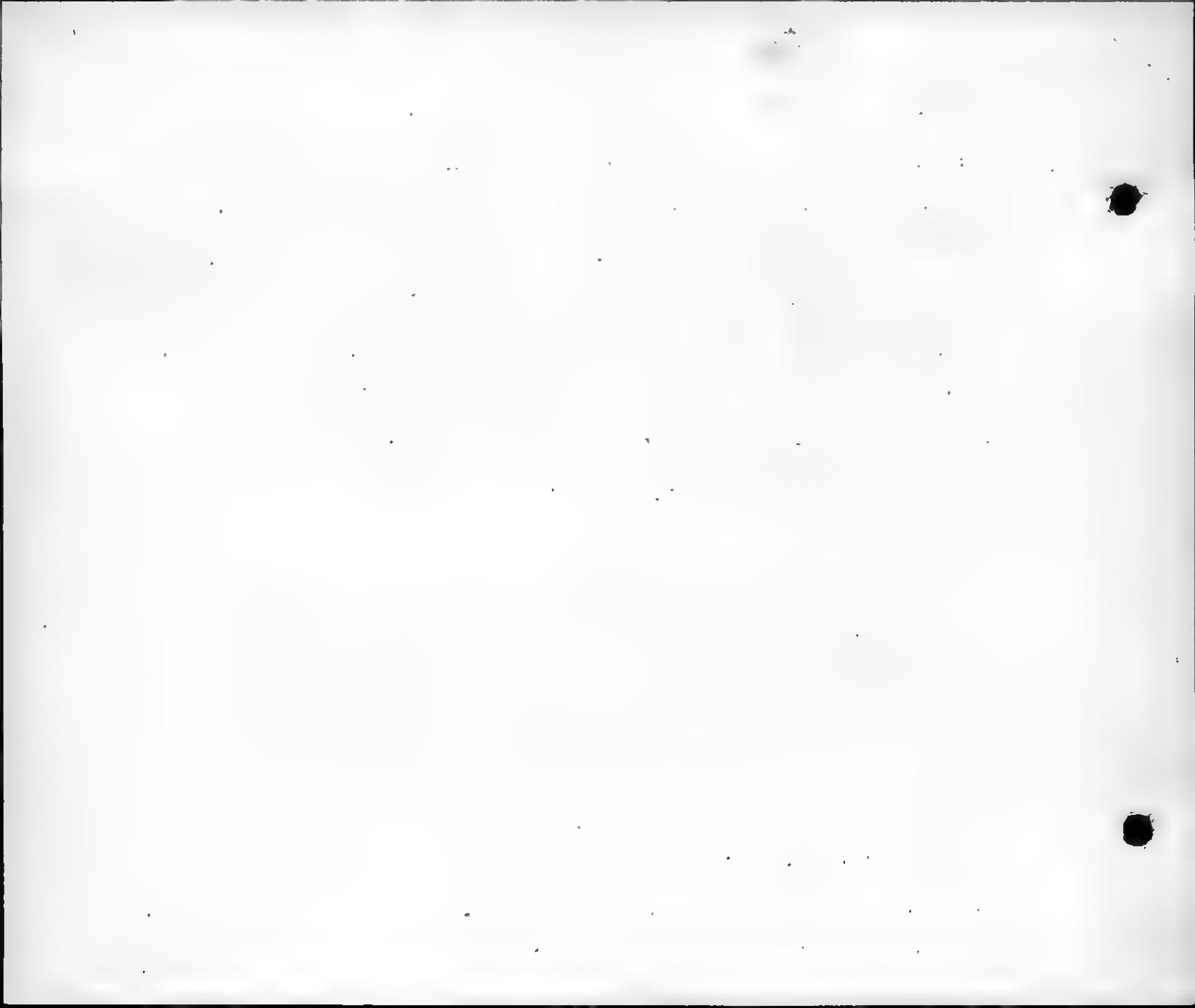
CERTIFICATE OF DEATH

Reg. Dist. No.

13652

TO HOSPITAL or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN lb 2 yrs.		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md.		b. COUNTY Wicomico	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 521 Beuna Vista Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JANIE	Middle J.	Last PARSONS	4. DATE OF DEATH Month Dec. Day 8 Year 1959	Month Dec. Day 8 Year 1959	Month Dec. Day 8 Year 1959	Month Dec. Day 8 Year 1959	Month Dec. Day 8 Year 1959	
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2/19/78	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min.				
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Julius Jones			14. MOTHER'S MAIDEN NAME Elisa Payne						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		INFORMANT Hospital records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile Psychosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) White at work							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Stockton	(County) Maryland	(State) 13652		
21. I certify that I attended the deceased from Aug 26 , 1957, to Dec 8 , 1957, that I last saw the deceased alive on Dec 8 , 1957, and that death occurred at 9:15 AM , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) E.S.S.Hospital, Cambridge, Md.									
DATE SIGNED 12-8-59									
ACTUAL SIGNATURE Thomas J. Dredge M.D.									
PHYSICIAN'S NAME (Type) Thomas J. Dredge									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-59	22c. NAME OF CEMETERY Methodist Cemetery	22d. LOCATION (City, town, or county) Stockton, Maryland						
23. FUNERAL DIRECTOR'S SIGNATURE Henry J. Watson		ADDRESS Pocomoke City, Md.	24a. REC'D BY REGISTRAR DATE DEC 14 '59	24b. REGISTRAR'S SIGNATURE Orville S. Kraus					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. - Page 4
 may be rotated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 13653							
Items 8, 9 File # 12-21-59 et																	
CERTIFICATE OF DEATH																	
1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)																
a. COUNTY	Dorchester MARYLAND					a. STATE	Maryland										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rhodesdale - Rural					b. COUNTY	Dorchester										
c. LENGTH OF STAY IN 1b	Life					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Rhodesdale - Rural										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Reid's Grove					d. STREET ADDRESS	Reid's Grove					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year										
	Della	Mae	Rideout	December	13	19	59										
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.											
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 16, 1958	1 yrs.	Months	Days	Hours	Min									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY								
None			—			Dorchester Co., Maryland			U.S.A.								
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME											
Leroy Rideout						Anna Davis											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or date of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address								
No			None			Leroy Rideout, Rhodesdale, Maryland, RFD											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: <i>Bron Ch. Pneumonia Bilateral</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>																	
IMMEDIATE CAUSE (a) DUE TO																	
441X																	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO																	
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
Hour a. m. p. m. 19			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>														
21. I certify that I attended the deceased from <i>Dec 12, 1959</i> , to <i>Dec 12, 1959</i> , that I last saw the deceased alive on <i>Dec 12, 1959</i> , and that death occurred at <i>8:15A.M.</i> from the causes and on the date stated above.																	
ADDRESS (Street, city or town, state)																	
ACTUAL SIGNATURE <i>W. E. Lennon</i> M.D. Federalburg, Maryland DATE SIGNED 12-14-59																	
PHYSICIAN'S NAME (Type) W. E. Lennon, M.D.																	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 14, 1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Reid's Grove Cemetery</i>		22d. LOCATION (City, town, or county) <i>Reid's Grove, Maryland</i>		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frampton and Son, Federalburg, Maryland</i>						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <i>Cushing S. French</i>									
						DATE DEC 17 '59											

ARTHUR S. KRABUS, SEC'D.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13683

CERTIFICATE OF DEATH

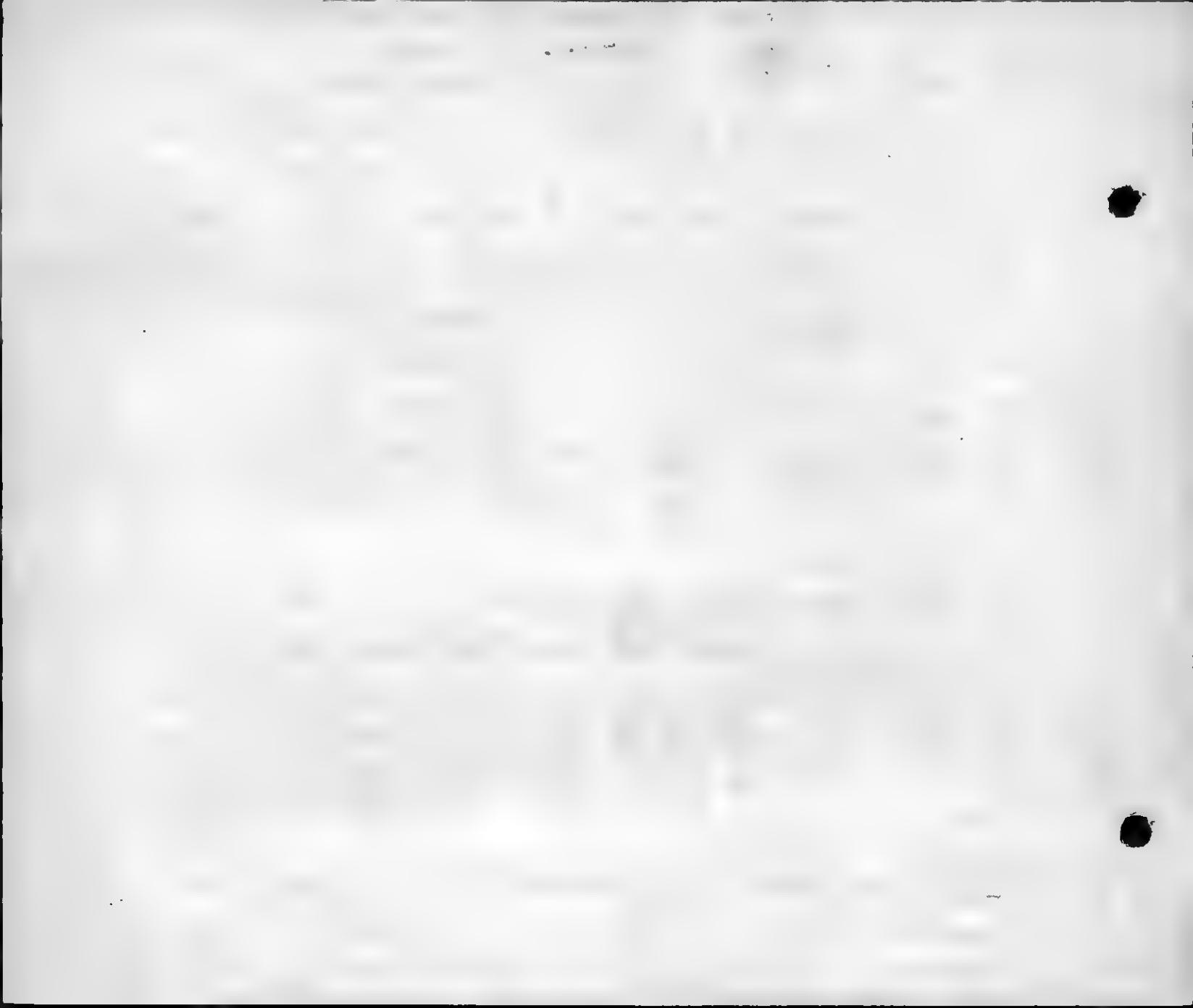
Reg. Dist. No.

13654

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Wichestor.				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Wichestor.		From 3/7/59.		Salisbury.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Eastern Shore State Hospital.		418 Forest Lane			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
John		HENRY	Savage.	December 24	Year 1959
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 63 yrs.
Male.		W.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/29/1894	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired salesman		E. Shore State Hospital		Virginia.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John Savage.		Sara Buncin Bunch		U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
		214-10-6597		Address Eastern Shore State Hospital records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH sever. yrs.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		generalized arteriosclerosis with C.V. diseases.			
441X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) } DUE TO		Malignant Hypertension. " "			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
Psychosis with Cerebral arteriosclerosis.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ to _____, _____, and that I last saw the deceased alive on _____, _____, and that death occurred at: 8:30 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		Simon Vizkutis		M.D. E.S.S. Hospital, Cambridge, Md. 12/24/59	
PHYSICIAN'S NAME (Type)		Simon Vizkutis.			
22a. BURIAL, CREMATION, KINSAVA (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM	
Dec. 28/59		Tanner Cem.		22d. LOCATION (City, town, or county) Salisbury Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
Holloway & Co. Salisbury Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13684

CERTIFICATE OF DEATH

Reg. Dist. No.

13655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY DORCHESTER		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WICOMICO.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 5 yrs. 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EDEN		d. STREET ADDRESS R.D.# 1		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOSHUA		First	Middle	Lost	4. DATE OF DEATH DECEMBER 13 1959	Month	Day	Year
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH MARCH 6 1894	P. AGE (In years lost birthday) 65 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HELPER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) MARYLAND (Wango)		12. CITIZEN OF WHAT COUNTRY? Z.U.S.A.		
13. FATHER'S NAME PETER S SMACK		14. MOTHER'S MAIDEN NAME Elizabeth Arvey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Stella Bozman (Sister) Address PEARL SMACK EDEN MARYLAND				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X		DUE TO LOBAR PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO EPILEPSY		53 YEARS				
(c)		CORONARY OCCLUSION		4 HOURS				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state) EDEN MARYLAND						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) EDEN MARYLAND		20f. (City or town) (County) EDEN MARYLAND		(State) MARYLAND
21. I certify that I attended the deceased from APRIL 25, 1957 , to DEC. 13 1959 , that I last saw the deceased alive on DECEMBER 12 1959 , and that death occurred at 4:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) EDEN MARYLAND DATE SIGNED DECEMBER 13 1959								
ACTUAL SIGNATURE Harry J. Crawford.		M.D. EASTERN SHORE STATE HOSP-CAMBRIDGE DEC 13 1959						
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1959		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery-R.D# Powellville, Maryland		22d. LOCATION (City, town, or county) (State) MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13672

CERTIFICATE OF DEATH

Reg. Dist. No.

13656

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b 2 Month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 207, W. Appleby		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Lester Q. Thomas		First	Middle	Last	4. DATE OF DEATH Month 12	Day 5	Year 1959
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1/11/1885	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. Thomas		14. MOTHER'S MAIDEN NAME Mary Todd		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Netha Thomas, Wingate, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Medullary paralysis, progressive		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		Cerebral thrombosis progressive		INTERVAL BETWEEN ONSET AND DEATH 2 mos	
DUE TO (b)		(c) Arterio-sclerosis generalized				?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual Lt. hemiplegia due to above						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1959 to Dec 5 1959 , that I last saw the deceased alive on Dec 5 1959 , and that death occurred at Cambridge, Md. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Cambridge, Md.		DATE SIGNED 12/7/59	
ACTUAL SIGNATURE J. Thompson M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/7/59		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 14 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Tamm	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

the first time in all
my life I have been
so much surprised.
It was so different.

John is well
now. He is going to
see his old friends

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

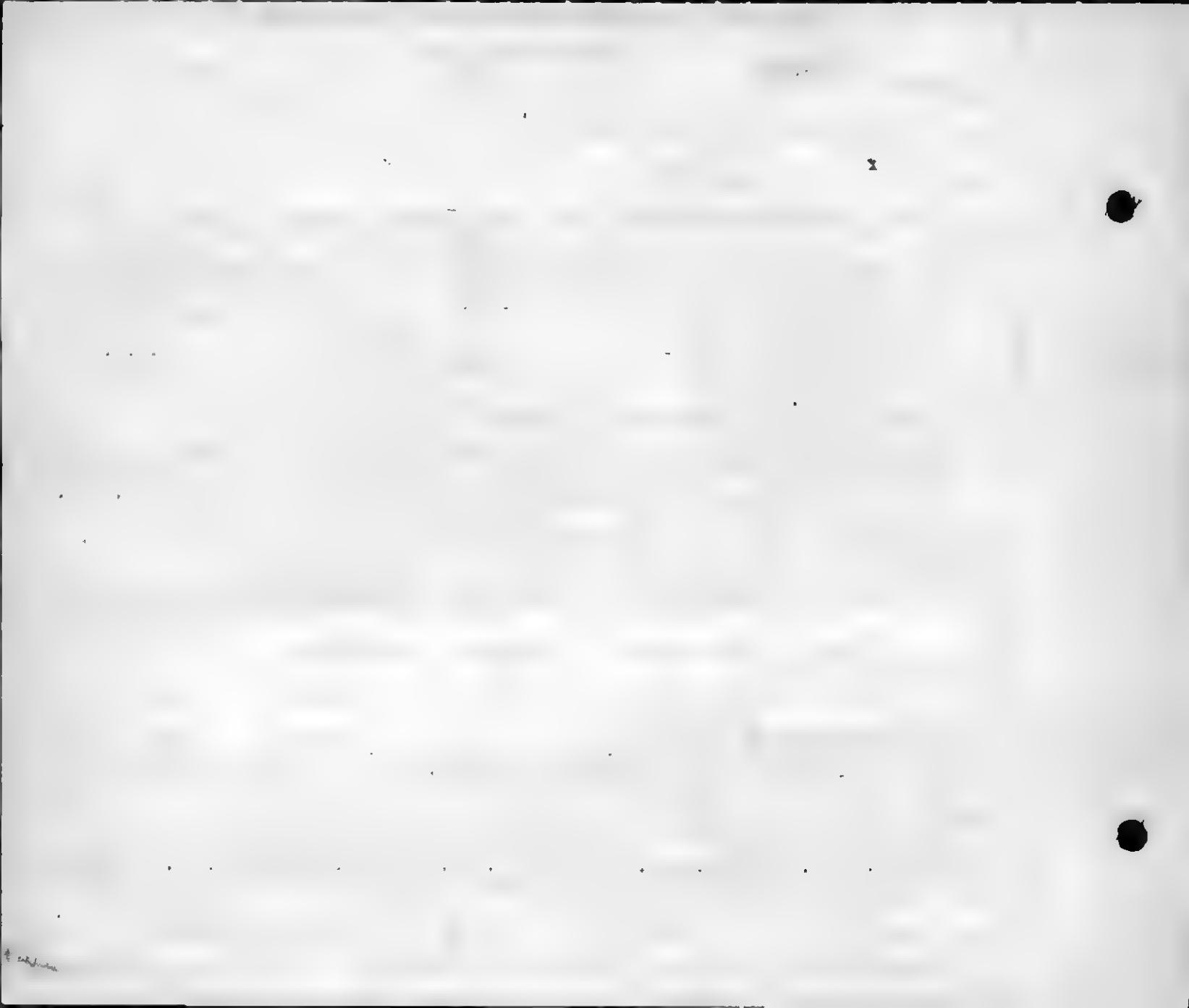
13658

CERTIFICATE OF DEATH

Reg. Dist. No.

13685

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingston		d. STREET ADDRESS --	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Theodore	Last Turpin	4. DATE OF DEATH December 23 1959	Month Year	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5-28-84	9. AGE (In years last birthday) 75 yrs.	F. UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred B. Turpin		14. MOTHER'S MAIDEN NAME Elizabeth Bell Turpin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. --		17. INFORMANT Eastern Shore State Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH Sev. yrs.					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Generalized Arteriosclerosis		10 yrs. plus					
DUE TO 44-120-5							
DUE TO Generalized Arteriosclerosis							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19 1959 , to 12-23 1959 , that I last saw the deceased alive on 12-23 1959 , and that death occurred at 7:30a.m. from the causes and on the date stated above. ACTUAL SIGNATURE <i>George E. Currier</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED					
PHYSICIAN'S NAME (Type) George E. Currier, M.D.		E.S.S. Hospital, Cambridge, Md. 12-23-59					
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/26/59		22b. DATE THEREOF 12/26/59		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul's Cemetery		22d. LOCATION (City, town, or county) Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. Harvey Bradshaw Crisfield Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Moore</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13686 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13659

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Md. b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 30 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) E.S.S. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield	
d. STREET ADDRESS ?		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruby Roach Tymerson		4. DATE OF DEATH Dec. 5 1959	
5. SEX F COLOR OR RACE W MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH 4/26/94		9. AGE (In years from birthday) 65 yrs.	
W WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Roach		14. MOTHER'S MAIDEN NAME Elizabeth Lawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For no. or rank/branch) None		16. SOCIAL SECURITY NO. -	
17. INFORMANT Records E.S.S. Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, if any, which gave rise to immediate cause (b)			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		DATE SIGNED 12/5/59	
NAME (Type) John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 8, 1959	
22c. NAME OF CEMETERY OR CREMATORIUM ROACH CEMETERY		22d. LOCATION (City, town, or county) CRISFIELD	
23. FUNERAL DIRECTOR'S SIGNATURE BRADSHAW & SONS		24a. REC'D BY REGISTRAR DATE DEC 9 '59	
ADDRESS CRISFIELD, MD.		24b. REGISTRAR'S SIGNATURE C. B. & K. KELLY	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13673

CERTIFICATE OF DEATH

Reg. Dist. No.

13661

1. PLACE OF DEATH a. COUNTY Dorchester Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Tubunan Apts.		e. STREET ADDRESS Tubunan Apts.		d. STREET ADDRESS Tubunan Apts.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Erik	Middle Townsend	Last Windsor	4. DATE OF DEATH 12	Month 11	Day 19	Year 59
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 4/28/1959	9. AGE (In years last birthday) 0 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 7			Days 13	Hours -	Min. -
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Ronald Windsor	14. MOTHER'S MAIDEN NAME Nancy Townsend
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT Mr Ronald Windsor, Tubunan Apts. Cambridge, Md.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) <i>Congenital Hydrocephalus</i>	INTERVAL BETWEEN ONSET AND DEATH 7 mos
<i>Congenital Cephalomeningocele</i>	7 mos

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Other congenital anomalies chest & abdomen</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from 4-28-1959 to 12-11-1959 , that I last saw the deceased alive on 12-11-1959 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.				
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ACTUAL SIGNATURE <i>J.W. Bannister</i>	M.D.	ADDRESS (Street, city or town, state) Cambridge	DATE SIGNED 12-12-59
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PHYSICIAN'S NAME (Type) Le Compte Funeral Service	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/12/59	22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Mem. Park.	22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.
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23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE DEC 29 59	24b. REGISTRAR'S SIGNATURE Arthur S. Trahan
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 3 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13687 CERTIFICATE OF DEATH

Reg. Dist. No.

13660

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Hanover</i>		<i>Baltimore County, Md.</i>		<i>6/2/59</i>		a. STATE <i>Md.</i> b. COUNTY <i>Wicomico</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<i>Euston Street Hospital.</i>				<i>Salisbury.</i>			
d. STREET ADDRESS							

3. NAME OF DECEASED (Type or print)	First <i>James</i>	Middle <i>Leopold</i>	Last <i>Warwick</i>	4. DATE OF DEATH	Month <i>Dec.</i>	Day <i>19</i>	Year <i>1954</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/25/1875</i>	9. AGE (In years lost birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Faznitz.</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
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13. FATHER'S NAME <i>John Warwick</i>	14. MOTHER'S MAIDEN NAME <i>Francis Parker.</i>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	<i>No.</i>	<i>Hospital records.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH <i>same day</i>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>156.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) Cancer of liver.</i> (c) <i>Cancer of liver.</i>	

MEDICAL CERTIFICATION	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Senile Psychosis.</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
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20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Ess. of Cambridge, Md.</i>	(County) <i>Wicomico Co.</i>	(State) <i>Md.</i>
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21. I certify that I attended the deceased from <i>6/2/59</i> , 1959, to <i>DEC 19</i> , 1959, that I last saw the deceased alive on <i>DEC. 19</i> , 1959, and that death occurred at <i>1450 18th St.</i> M., from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <i>1450 18th St. Wicomico Co. Md.</i>	DATE SIGNED <i>12/19/54</i>
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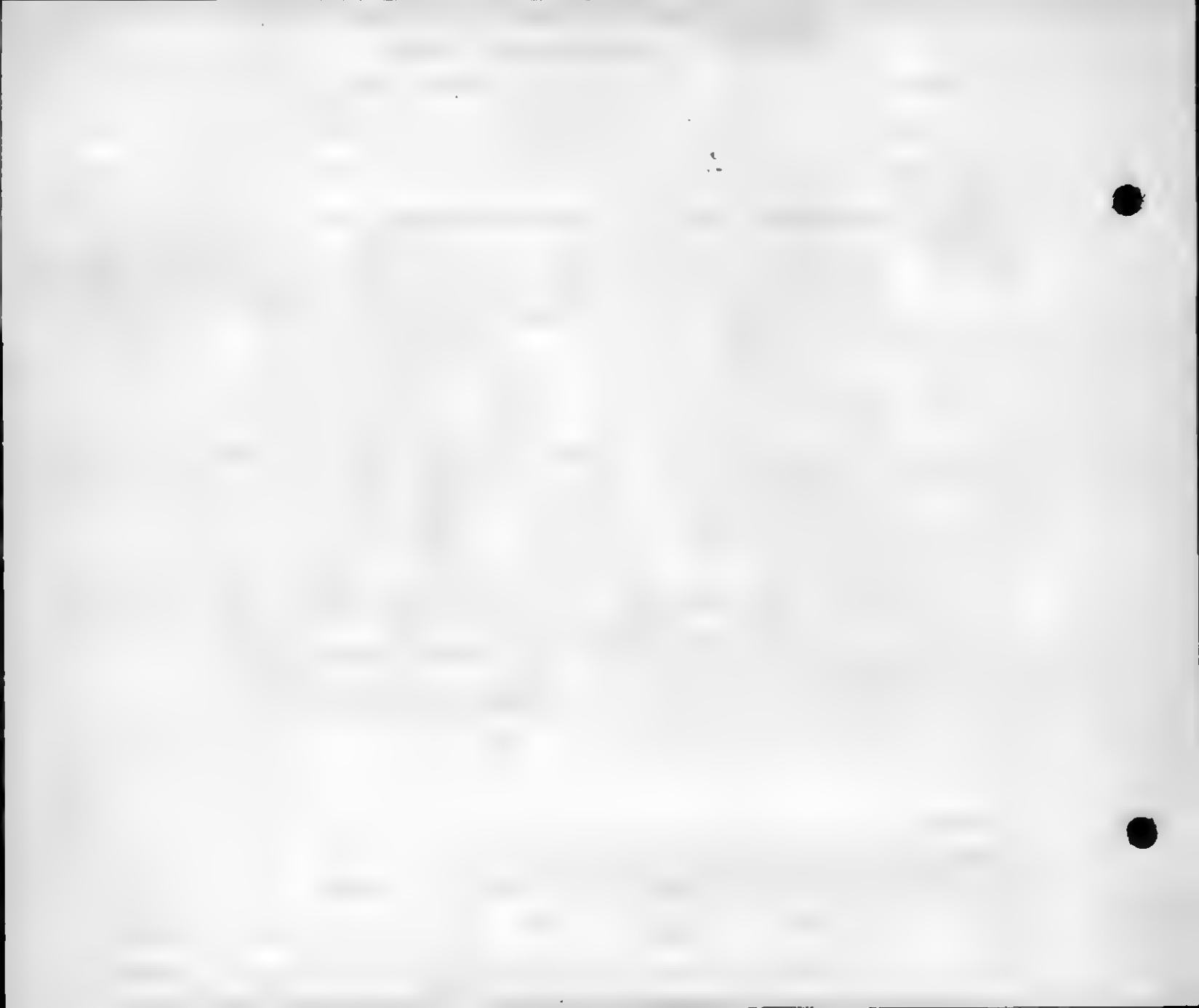
ACTUAL SIGNATURE <i>Simon Vizkutis</i>	PHYSICIAN'S NAME (Type) <i>Simon Vizkutis.</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/22/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Taylor Cemetery</i>	22d. LOCATION (City, town, or county) <i>Salisbury Md.</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>James Henman</i>	ADDRESS <i>Theresa Anne</i>	24b. REC'D BY REGISTRAR <i>DEC 3 0 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13662

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D.		c. LENGTH OF STAY IN 1b 6 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, R.D. 2		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna Lucille	Middle Woolford	Last	4. DATE OF DEATH	Month Dec. 13, 1959	Day	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 4, 1890	9. AGE (In years from birthday) 69 yrs.	IF UNDER 1 YEAR Months 5	IF UNDER 24 HRS. Days Min.	Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemakers		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Centreville, Md. R.D.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert Greaves		14. MOTHER'S MAIDEN NAME Minerva (last name unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Calvin Woolford, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus INTERVAL BETWEEN ONSET AND DEATH 5 Min.							
822X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Fracture neck femur, 6 wks.							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? 20a. EXTERNAL CAUSE WAS PRINCIPAL <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in auto which overturned.							
20c. TIME OF INJURY Month, Day, Year 5 P.M. 10/31 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Nr. Marydel (County) Del. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/15/59	
EXAMINER'S NAME (Type) Dr. John Mace Jr.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Dec. 16, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lorraine R. Howard</i>		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DEC 18 '59		24b. REGISTRAR'S SIGNATURE <i>Collier S. Howard</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BY COMMITTEE ON THE STATE OF THE UNION
HABEAS TO STAGGERED PUNISHMENT

1967

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13674

CERTIFICATE OF DEATH

Reg. Dist. No.

13663

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b entire life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Ave.		d. STREET ADDRESS 1 Maryland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daniel	Middle Henry	Last Wright, Jr.	4. DATE OF DEATH Dec. 12, 1959	Month Day Year 19		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 24, 1911	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) State Employment Office Worker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Henry Wright, Sr.,		14. MOTHER'S MAIDEN NAME Ruth Brown		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World War 2 215-16-3006		17. INFORMANT Mrs. Ida S. Wright, Maryland Ave., Cambridge, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO Hypertension & Cardiovascular Disease (c) INTERVAL BETWEEN ONSET AND DEATH 3 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-9 , 1959, to 12-12 , 1959, that I last saw the deceased alive on 12-12 , 1959, and that death occurred at 10.50 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE G. Bannister		PHYSICIAN'S NAME (Type) M.D.		ADDRESS (Street, city or town, state) Cambridge		DATE SIGNED 12-13-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Dorchester Memorial Park		22d. LOCATION (City, town, or county) Cambridge, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Renfrew L. Thorpe		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE DEC 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

THE STATE GOVERNMENT OF KENYA

CERTIFICATE OF DESIGN

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